Provider Enrollment Checklist for Behavioral Health Direct Service Provider

Qualified Behavioral Aide (QBA), Specialty 302

This checklist must be completed and submitted with the attachments listed below. If you have any questions, please contact the Provider Enrollment Unit at (877) 638-3472 from 8:00 a.m. to 5:00 p.m. Monday through Friday.

Provider Name: _____ Date: _____

National Provider Identifier (NPI): _____

Attachments

Initial each space below to signify that the specified item is attached.

____ SS-4, CP575 or W-9 form showing tax payer identification number (this may be the employer's tax ID; individual providers do not need their own tax ID if they are an employee of an entity/agency/group with a tax ID)

____ High School Diploma or General Education Development (GED) equivalent

____ Tuberculosis (TB) test with negative results or medical clearance as outlined in NAC 441.A375

____ Documentation showing that the provider completed the initial 16-hour competency and in-services training program as described in Nevada Medicaid Services Manual (MSM) Chapter 400, Section 403.6A.1b and a summary/outline of all course content

____ Copy of current cardio pulmonary resuscitation (CPR) certification

____ Verification of completion of Federal Bureau of Investigations (FBI) criminal background check

____ Provider Enrollment Application and Contract *(original document/signatures required)*

Policy Declaration

I hereby declare that I have read the current MSM Chapters 100, 400 and 3300 as of the date above and understand this policy and how it relates to my scope of practice. I acknowledge that, as a Nevada Medicaid-contracted provider, I am responsible for complying with the MSM, with any updates to this policy as may occur from time to time and with applicable state and federal laws.

Based on this understanding, I will abide by the scope of service, provider qualifications, service limitations and admission criteria detailed in Section 403.6C, Basic Skills Training (BST) Services.

I meet all provider qualifications outlined in MSM Chapters 100 and 400.

QBA Signature: _____ **Date:** _____

Policy Acknowledgement

By initialing each of the three bolded items below, I agree to conform to these policy requirements.

_____ **Service Delivery Models (MSM 403.1.c)**

Individual rehabilitative mental health providers (RMH) must meet the provider qualifications for the specific service. If they cannot independently provide clinical and direct supervision, they must arrange for clinical and direct supervision through a contractual agreement with a Behavioral Health Community Network

(BHCN) or qualified independent professional. These providers may directly bill Nevada Medicaid or may contract with a BHCN.

_____ Provider Standards (MSM 403.2A)

All providers must:

1. Provide medically necessary services;
2. Adhere to the regulations prescribed in Chapter 400 and all applicable Division chapters;
3. Provide only those services within the scope of their [the provider's] practice and expertise;
4. Ensure care coordination to recipients with higher intensity of needs;
5. Comply with recipient confidentiality laws and Health Insurance Portability and Accountability Act (HIPAA);
6. Maintain required records and documentation;
7. Comply with requests from the Qualified Improvement Organization (QIO)-like vendor [HP Enterprise Services];
8. Ensure client's [recipient's] rights; and
9. Cooperate with Division of Health Care Financing and Policy's (DHCFP's) review process.

_____ Rehabilitative Mental Health Services (MSM 403.6B.3c)

QBAs may provide BST services under the clinical supervision of a Qualified Mental Health Professional (QMHP) and the direct supervision of a QMHP or a Qualified Mental Health Associate (QMHA). Peer-to-peer support services must be provided under the clinical and direct supervision of a QMHP.

Changes to Medicaid Information

If your direct supervisor, clinical supervisor or employer change or any other pertinent information changes from what is presented above and on your enrollment application, you are required to notify HP Enterprise Services within five working days. To comply with this notification requirement, complete the relevant sections of form FA-33 (which is online at http://www.medicaid.nv.gov) and submit the form to HP Enterprise Services.

(Per MSM Chapter 100, Section 103.3 dated December 2008: Medicaid providers, and any pending contract approval, are required to report, in writing within five working days, **any change in ownership, address, or addition or removal of practitioners, or any other information pertinent to the receipt of Medicaid funds**. Failure to do so may result in termination of the contract at the time of discovery.)

I hereby accept Nevada Medicaid's change notification requirements:

QBA Provider Signature: _____ Date: _____

Clinical and Direct Supervisors

I understand that I must have clinical and direct supervision when providing services to Nevada Medicaid recipients. The name, title, contact phone and signature of my current clinical and direct supervisors are provided below.

Clinical Supervisor Name: _____

Qualified Behavioral Aide (QBA), Specialty 302

Professional Title (attach a copy of credentials/license): _____

NPI:_____ Contact Phone: _____

Clinical Supervisor Signature: _____

Direct Supervisor Name: _____

Professional Title (attach a copy of credentials/license): _____

NPI:_____ Contact Phone: _____

Direct Supervisor Signature: _____

Reporting Fraud

Providers have an obligation to report to the Division of Health Care Financing and Policy (DHCFP) any suspicion of fraud or abuse in DHCFP programs, including fraud or abuse associated with recipients or other providers (MSM Chapter 3300, Section 3303.1B.1). Examples of fraudulent acts, false claims and abusive billing practices are listed in MSM Chapter 3300, Section 3303.1A.2. Alleged fraud, abuse or improper payment may be reported by calling (775) 687-8405.

I understand that Nevada Medicaid payments are made from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws.

I hereby agree to abide by Nevada Medicaid's fraud reporting requirements:

QBA Provider Signature: _____ Date: _____